DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONS
REMOVAL FROM PROGRAMMING REPORT
(for offenders in administrative segregation, protective custody or cellblock housing)

DATE: _____ **ASSIGNED HOUSING:** _____

NDER NAME: _____ **JIRMS#** _____ **SMI/MR:** ☐ Yes ☐ No

PROGRAM REMOVAL/PROGRAM PARTICIPATION

Authorized By: _____ (Lieutenant or Higher)

Offender Removed from:
☐ Morning Programming ☐ Afternoon Programming ☐ Evening Programming

Time of Removal From Programming: _____ AM / PM

Reason for Removal From Programming: (Be Specific)

_____

_____

_____

_____

Was Offender Issued a Disciplinary Report: ☐ YES ☐ NO

If Yes, Specify Rule # and Violation: _____

Supervisor's Signature: _____ (Name/Title)

DOCUMENT OFFENDER INTERIM BEHAVIOR ON BACK OF FORM

SUPERVISOR EVALUATION
(Captain or Higher)

_____	Morning Evaluation	Afternoon Evaluation	Evening Evaluation
Time of Offender Evaluation By Ranking Security Supervisor:	(AM/PM)	(AM/PM)	(AM/PM)
Results of Ranking Security Supervisor Evaluation:	☐ Return to Programming ☐ Do Not Return to Programming	☐ Return to Programming ☐ Do Not Return to Programming	☐ Return to Programming ☐ Do Not Return to Programming
Ranking Security Supervisor Comments:			

Time of Release From Program Removal: _____ AM / PM

Was Offender Released Prior to Evening Recreation: ☐ Yes ☐ No

Does This Document (see back) Sufficiently Document Offender's Behavior While Removed From Programming: ☐ YES ☐ NO

Has This Offender Been Denied Participation in Three Consecutive Opportunities for Programming: ☐ YES ☐ NO

(If "YES," the following information must also be provided.)

Signature of Ranking Security Supervisor: _____ (Name / Title)

SERIOUS MENTAL ILLNESS / MENTAL RETARDATION ASSESSMENT
(to be completed if offender is seriously mentally ill or mentally retarded)
(If not-applicable write N/A across this section)

☐ Serious Mental Illness ☐ Mental Retardation

Time of Offender Assessment and Treatment by Mental Health Staff: _____ AM / PM

_____ essed by Qualified Nurse - Was the Qualified Mental Health Professional Contacted via _____ ione: ☐ YES ☐ NO

Was There a Need for a Face-to-Face Assessment by the Qualified Mental Health Professional: ☐ YES ☐ NO

Was Offender Recommended for Release from Cell Restriction to Another Location: ☐ YES ☐ NO

If Yes - Location: _____

Assessment and Treatment Conducted By: _____ (Name / Title)

Date: _____ **Offender Name:** _____ **JIRMS #** _____

Time	Offender Behavior	Time	Offender Behavior

Officer's Signature: _____ **(Name & Title)** **Shift:** _____

Date: ______________ **Offender Name:** ____________________________ **JIRMS #** ______________

Time	Offender Behavior	Time	Offender Behavior

Officer's Signature: ______________________________ **(Name & Title)** **Shift:** __________